

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 00-50	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE December 21, 2000	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

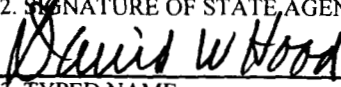
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.10; 42 CFR Part 447 Subparts B & C	7. FEDERAL BUDGET IMPACT: a. FFY <u>2001</u> \$15,388.63 12,080.07 b. FFY <u>2002</u> 50 15,917.08
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Item 1, Page 8a Attachment 4.19-B, Item 2.a., Page 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): None-New Page Same (TN 00-22) pending approved 03/08/2001

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to modify the reimbursement methodology for hospital inpatient and outpatient services to include a supplemental payment for state fiscal year 2001 to be issued to qualifying non-state public hospitals, not recognized by the Department as a small rural hospital, for unreimbursed Medicaid costs incurred in providing care to Medicaid recipients.**

11. GOVERNOR'S REVIEW (Check One):

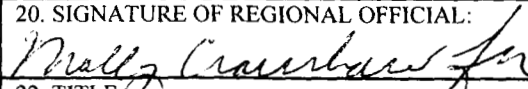
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material.**

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: David W. Hood	
14. TITLE: Secretary	
15. DATE SUBMITTED: December 20, 2000	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 29, 2000	18. DATE APPROVED: July 5, 2001
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: December 21, 2000	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Calvin G. Cline	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS: **Pen & int changes per State's letter dated 4/3/01.**

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

7. The following payments shall be made in addition to the prospective rate described above. (Continued)

c. Supplemental Payment

A supplemental payment for the current State fiscal year for inpatient hospital services shall be issued to qualifying non-state public hospitals (other than those recognized as small rural hospitals) for unreimbursed Medicaid costs incurred in providing care to Medicaid recipients. A qualifying provider is defined as any public provider owned by a parish, city or other local government agency or instrumentality. This definition includes facilities owned jointly by two or more government entities, but does not include facilities owned jointly by government and private organizations.

The supplemental payment shall be calculated from each hospital's latest audited Medicaid cost report as identified by the Department. The payment amount shall be determined by subtracting the actual Medicaid reimbursements from the total Medicaid costs as calculated from the audited cost report. The Medicaid reimbursements and Medicaid costs shall include inpatient (acute and psychiatric) hospital services. This amount shall then be inflated forward to the current State fiscal year using the annual Medicare PPS Marketbasket Index. Supplemental payments shall be distributed on a quarterly basis to qualifying hospitals. There will be no adjustment to this payment if additional costs are identified subsequent to the completion of the audit process.

STATE <u>Louisiana</u>	A
DATE REC'D <u>12-29-2000</u>	
DATE PPV'D <u>07-05-2001</u>	
DATE EFF <u>12-21-2000</u>	
HCFN <u>LA-00-50</u>	

TN# 00-50 Approval Date 07-05-2001 Effective Date 12-21-2000

Supersedes

TN# **SUPERSEDES: NONE . NEW PAGE**

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Outpatient hospital services other than clinical diagnostic laboratory, outpatient surgeries, and rehabilitation services are paid as follows:

In-state private hospital outpatient services are reimbursed on a hospital specific cost to charge ratio calculation based on filed cost reports for the period ending in state fiscal year 1997. Final reimbursement is adjusted to 83% of allowable cost through the cost report settlement process.

In-state public hospital outpatient services are reimbursed at an interim rate of 60% of billed charges. Final reimbursement is adjusted to 83% of allowable cost through the cost report settlement process.

Out-of-state hospital outpatient services are reimbursed at 50% of billed charges.

Supplemental Payment

A supplemental payment for the current State fiscal year for outpatient hospital services shall be issued to qualifying non-state public hospitals (other than those recognized as small rural hospitals) for unreimbursed Medicaid costs incurred in providing care to Medicaid recipients. A qualifying provider is defined as any public provider owned by a parish, city or other local government agency or instrumentality. This definition includes facilities owned jointly by two or more government entities, but does not include facilities owned jointly by government and private organizations.

The supplemental payment shall be calculated from each hospital's latest audited Medicaid cost report as identified by the Department. The payment amount shall be determined by subtracting the actual Medicaid reimbursements from the total Medicaid costs as calculated from the audited cost report. The Medicaid reimbursements and Medicaid costs shall include outpatient hospital services. This amount shall then be inflated forward to the current State fiscal year using the annual Medicare PPS Marketbasket Index. Supplemental payments shall be distributed on a quarterly basis to qualifying hospitals. There will be no adjustment to this payment if additional costs are identified subsequent to the completion of the audit process.

STATE <u>Louisiana</u>	A
DATE REC'D <u>12-29-2000</u>	
DATE APP'D <u>07-05-2001</u>	
DATE EFF. <u>12-21-2000</u>	
HCFA 179 <u>LA-00-50</u>	

TN# 00-50 Approval Date 07-05-2001 Effective Date 12-21-2000
Supersedes
TN# 00-22